THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-4569.M5

MDR Tracking Number: M5-04-0153-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 9-10-03.

The IRO reviewed office visits, electrical stimulation, mechanical traction, and manual traction from 9-19-02 through 12-27-02.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. The disputed date of service 9-9-02 is untimely and ineligible for review per TWCC Rule 133.307 (d)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. The Commission received the medical dispute on 9-10-03.

On 11-24-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Neither party submitted EOBs for CPT codes 97032, 97012, 99354, 99070, and 97122 for dates of service 9-19-02 through 10-30-02; therefore, this review will be per the 1996 *Medical Fee Guideline.* The requestor did not submit relevant information in accordance with Rule 133.307(g)(3) to support delivery of service for the disputed dates of service. Therefore, no reimbursement recommended.

The above Findings and Decision are hereby issued this 18th day of February 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 11/26/03

MDR Tracking No. M5-04-0153-01

November 14, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Notice of Independent Review Determination

CLINICAL HISTORY
Based on available information, it appears that this patient reports a back injury related to pushing a vacuum cleaner while at work on ___. The patient presented initially to her chiropractor___ who diagnosed her with lumbar disc syndrome and multiple additional lower back disorders. Chiropractic history suggests no presence or evaluation of pre-existing conditions. Treatment appears to be provided initially on a daily basis with multiple passive modalities. As treatment

progresses, the patient is provided with some therapeutic exercises and ADL instruction. The patient is referred for orthopedic consult with ___, on ___. History provided by ___ suggests significant past back problems treated on a frequent and regular basis with her chiropractor since 1983. There is also mention of a previous injury to her lower back occurring on ___ as a result of her being pulled and jerked by her dog. ___ provides medications and recommends a muscle conditioning therapy program. He also indicates that the patient should be reassessed if pain and dysfunction persists with conservative care. An MRI is performed 2/14/97 suggesting mild-moderate central-left L4/5 HNP.

Chiropractic care and therapy is continued ongoing through the rest of 1997, 1998 and 1999 on a PRN basis. The patient appears to be seen only once in 2000 and then resumes PRN care for several sessions in 2001 and 2002. All of these treatments appear to include both chiropractic manipulations and passive modalities. No specific evaluation of exacerbation or re-injury appears to be noted other than "static w/exacerbation" from progress notes. Patient also appears to receive treatment for undiagnosed cervical and thoracic conditions that appear unrelated to work injury. Chiropractic notes are submitted from 9/19/02 through 12/27/02. Patient's conditions appear essentially unchanged through this period with little change in chiropractic treatment and passive modality applications. No orthopedic or medical reassessment appears to be made or ordered. As of 12/27/02, chiropractor appears to continue manipulation and multiple passive modalities for cervical, thoracic and lumbar conditions.

REQUESTED SERVICE(S)

Determine medical necessity for chiropractic services (Items in Dispute including office visits, electric stimulation, mechanical and manual traction) provided 9/19/02 through 12/27/02.

DECISION

Chiropractic services (office visits and passive modalities) provided from 9/19/02 through 12/27/02 are not supported by documentation provided from treating doctor. Medical necessity for level, frequency and duration of care for conditions identified are not supported by rationale given.

RATIONALE/BASIS FOR DECISION

Ongoing pain and discogenic symptoms of this nature would appear to require reassessment and evaluation with qualified orthopedic or medical spine specialist if conditions persist beyond conservative care. If discopathy or clinically significant radiculopathy were present, appropriate neurodiagnostic testing, orthopedic and/or neurosurgical consultation would be indicated prior to continuation of chiropractic care beyond initial phase treatment in 1997. In addition, no such re-examination or reevaluation is found for review beyond ___ report from 1/29/99.

Also, generally accepted standards of care and spine treatment guidelines do not support ongoing passive modality applications beyond acute phase of care (8-12 weeks post injury). Ongoing passive applications of this nature suggest no further potential for restoration of function or progressive resolution of symptoms. Periodic exacerbations do not appear to be well documented or causally related to work related injury.

1 Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings

2 from the UCLA Low Back Pain Study, J Manipulative Physiol Ther 2002; 25(1):10-20.

3 Bigos S., et al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.

4 Hoving JL, Koes BW, de Vet HCW, van der Windt DAWM, Assendelft WJJ, van Mameren H, et al. Manual therapy,

5 physical therapy or continued care by a general practitioner for patients with back pain. A randomized, controlled trial. Ann Int Med 2002; 136:713-722.

6 Morton JE. Manipulation in the treatment of acute low back pain. J Man Manip Ther 1999; 7(4): 182-189.

7 Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review.

This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.